STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006605	A. BUILDING: _____ B. WING _____	C 11/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S3240	Section 300.3240 Abuse and Neglect This Regulation is not met as evidenced by: Statement of Licensure Violations: 300.3240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that another resident of the long term care facilities the perpetrator of the abuse, that residents condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) Based on interview and record review the facility failed to monitor resident behaviors and implement interventions to prevent physical abuse for two (R2 and R4) of four residents reviewed for abuse. The findings include: 1. R4 has a history of bipolar disorder, anxiety disorder and schizophrenia. As documented on the July 2015 physician order sheet. On 6/28/15 at 8:45 AM, R4's nursing notes document R4 was agitated and took the fire extinguisher from the hall and aimed it and sprayed staff. The notes document R4 was placed on 1:1 observation immediately. The nursing notes also document at 9:30 AM , the same day, a CNA (Certified Nursing Assistant) notified the staff nurse R4 was in an altercation with another resident in the dining room.	S3240	Attachment A Statement of Licensure Violations	

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S3240	Continued From page 1 E4's (SSD, Social Service Director) notes document R4 pushed another resident and that resident "poked" R4 in the mouth and knocked out three of R4's teeth. R4's nursing notes document R4 was sent out to the hospital at 10:00 AM. The nursing notes document R4 was on 1:1 observation. On 11/3/15 at 3:30 PM, E1 (Administrator) stated there is no policy on acute psychotic behavior monitoring nor is there a policy on 1:1 observations or how the staff is guided to perform 1:1 observations. On 11/3/15 at 3:45 PM, E5 (LPN) stated 1:1 observations must be initiated by a physician and cannot be stopped until discontinued by a physician. E5 stated when a resident is on 1:1 observation they must be physically seen at all times. It is not clear who is responsible to observe the resident or where they should be placed for observation. There is no specific documentation for 1:1 monitoring. On 8/7/15 R4 had another altercation with R3. The facility investigation documented R3 was in the men's bathroom and R4 came in to use it and pushed R3 out of the way, R3 lost his balance and fell. R3 sustained a fractured finger and multiple abrasions and was sent to the hospital. The nursing notes document R3 was in his wheelchair and was pushed from his wheelchair by R4. R4 was also sent to the hospital for an evaluation. There was no update in R4's care plan post psychiatric hospitalization to guide staff on any new changes on R4's behavior assessment and care of the resident.	S3240		

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S3240	Continued From page 2	S3240		

2. R2 has a history of delusions, paranoia, bipolar, schizo-affective disorder and aggressive behavior as documented on the October 2015 physician order sheet.

The facility investigation report on 10/19/15 documents R2 struck another resident on the head with a chair. R2 was placed on 1;1 monitoring but was not transferred to the hospital for behavioral evaluation until 9:00 PM that night. There is no documentation of the 1:1 monitoring during that period or who was doing the monitoring.

R2's care plan was also not updated upon return from a psychiatric hospitalization for staff guidance on changes to care or behaviors.

E4 (PRSD, psychiatric rehabilitation services director) states she did not update R2's care plan since admission back from the psychiatric hospitalization. E4 stated she remembers talking to E3 about it so wrote down the date 10/19/15 on the care plan on 11/3/15. There was no note from E4 on the recent behavior that occurred with R4 or any new or changed interventions that were put in place.

(B)